



Health Information : 2020-2021

Student Name: _____ Date of Birth: _____

Allergies: _____

In case of allergic reaction: _____

Name of Child's Doctor: _____ Phone #: _____

Previous operations / hospitalizations:

Please note any medical conditions that we should be aware of (i.e. asthma, diabetes, etc.):

Is your child currently taking any medication on a regular basis? _____

Would this medication be administered at school? _____

(If so, please complete a Medication Consent Form Available online)

Physical Limitations: _____

Is your child currently receiving special professional services? (i.e. speech therapy, physical therapy):

By signing below, I verify that the statements above are true to my knowledge and that I understand that it is my responsibility to inform the school of any new health conditions that may arise in my child, including exposure to persons infected with Covid-19.

Parent's Signature

Parent's Cell Phone

Home Phone

Parent's Cell Phone

Date

Other Contact Number